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ABSTRACT

This third chapter in "The Challenge of Counseling in Middle Schools" contains four articles on peer pressure and drug abuse in early adolescence. "Initiation of Alcohol and Drug Abuse in the Midel School Years," by Robert Hubbard, Rebecca Brownlee, and Ron Anderson, presents a study designed to provide a prospective assessment of the nature and extent of alcohol and drug abuse among middle school youths. "A Counseling Approach to Alcohol Education in Middle Schools," by Emily Garfield Ostrower, describes a curriculum and program, specifically for middle school students, to focus on alcohol and the personal problems associated with alcoholism. "Preventing Adolescent Drug Abuse," by Lindy LeCoq and Dave Capuzzi, describes an eight-session model for a group counseling program within the school setting for preventing drug abuse. "Drug Information: The Facts About Drugs and Where to Go for Help," by Edwin Gerler, Jr. and Stephen Moorhead, presents facts about drugs, their effects, and evidence of abuse. Included are discussions of alcohol, cannabis, stimulants, inhalants, cocaine, psychedelics, depressants, narcotics, and designer drugs. Sources of additional drug information are provided. (NB)

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Chapter 3

The Challenge of Peer Pressure and Drug Abuse in Early Adolescence

Early adolescence is a time of experimentation with new behaviors and of reliance on peers for guidance and direction. This combination can have devastating effects on young people's lives if it results in experimentation with alcohol and other drugs. Young people who begin to use alcohol and other mind altering substances during their middle school years may be especially prone to the problem of addiction later in adolescence and into adulthood.

Most middle schools are not prepared to offer adequate prevention programs to help youngsters challenge the social pressure to experiment with drugs. In fact, the current status of drug education in schools throughout the United States is ambiguous at best. Many of the programs offered to counselors for implementation in middle schools, for instance, have not been tested thoroughly and are not well grounded in human development theory. Theory-based prevention programs that have been tested or that are currently being tested offer hope that drug abuse prevention programs will improve over the next few years. Assertiveness training programs, for example, that are designed to help adolescents resist peer pressure, seem to offer middle school counselors intriguing ideas for program development. In addition, cognitive-development programs that are intended to raise the psychological maturity of youngsters

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and improve their decision-making offer considerable hope for middle school counseling programs.

This chapter (a) helps middle school counselors understand the relationship between peer pressure and substance abuse and (b) presents educational strategies that are designed to prevent drug abuse by helping young adolescents deal with the pressures to use drugs. The chapter offers two articles that focus on education and prevention. Emily Ostrower's article, *A Counseling Approach to Alcohol Education in Middle Schools*, is particularly noteworthy since alcohol continues to be the most accessible and most commonly abused substance during adolescence. Lindy LeCoq and Dave Capuzzi advocate a broad-spectrum approach to drug education offering elements of effective assertiveness training and decision-making programs.

The concluding article in this chapter presents a comprehensive look at drug information which middle school counselors can use to inform themselves and their students about the dangers inherent in the most commonly abused substances. As noted in the article, if counselors elect to present this information to students, they must do so in the context of comprehensive drug education programs that offer students opportunities to explore thoughts and feelings about drug use.

Initiation of Alcohol and Drug Abuse in the Middle School Years

Robert L. Hubbard
Rebecca F. Brownlee
Ron Anderson

The evidence of initiation of abuse of alcohol and drugs early in adolescence (Rachal et al., 1980) supports the need for prevention programs for middle school students. More recent findings suggest that children are beginning to experiment with drugs at a younger age. Only 1.1% of graduating seniors in 1975 reported using drugs as early as 6th grade, but 4.3% of seniors in 1985 reported drug use at this age (Johnston, O'Malley, & Bachman, 1985). Surveys for specific drugs also showed regular patterns of use and heavier use among younger age groups in recent years (Johnston, O'Malley, & Bachman, 1985; Newcomb, Maddahian, Skager, & Bentley, 1987).

The younger adolescent or preadolescent who begins to use alcohol and drugs may be at an even greater risk for regular use and related-problem use than those who initiate use later in adolescence. For example, early use may extend the period of involvement with drugs for the typical adolescent and allow for greater levels of involvement before drug use declines in the early 20s. Early use may increase opportunities to be exposed to more substances during ages when experimentation with drugs is high (Kandel, 1975). In addition, early initiation to drugs, especially before the age of 25, has been linked to a variety of adverse outcomes occurring later in life including increased levels of drug use (Welte & Barnes, 1985; Kandel, 1982), involvement with more substances (Kandel, 1982), and alcohol and drug related problems (Kandel, 1982; Rachal et al., 1980).

Despite the importance of learning more about initiation of alcohol and drug abuse in the middle school years, most of the available data on initiation is based on retrospective reports of youth interviewed later in adolescence. Few studies have examined the nature and extent of alcohol and drug abuse during middle school years; even fewer have included data on youth in the sixth grade. The purpose of the current study is to

present a prospective assessment of the nature and extent of alcohol and drug abuse among middle school youths. This assessment was the first stage of a comprehensive study of community-and school-based prevention programs for middle school students.

Method

The study involved students in 13 middle, junior high, and elementary schools in a rapidly growing southeastern county of 300,000. The schools participating in the prevention served approximately two-thirds of the middle school students in the county public school system. Eight of the schools served the urban and adjacent suburban populations of the major city of 150,000. Another five schools served a population from rural and mostly suburban areas of the county.

The initial data were collected in the fall of 1985 for urban/suburban schools and in the fall of 1986 for the rural/suburban students. Information forms explaining the study, offering to answer any questions and requesting cooperation, were printed on school stationery and signed by school and prevention program administrators and the principal investigator. A copy was mailed to the students' home. Parents were asked to sign and return forms if they did not want their child to participate.

The data collection procedure was a classroom administration of self-report questionnaires. The procedures were originally developed for a national survey of 7th- to 12th-grade students (Rachal et al., 1980) and is similar to those currently used in national (Johnston et al., 1985) and state (Welte & Barnes, 1985) studies. Trained survey interviewers, who were monitored by a field supervisor, administered the questionnaire. All questionnaire administration sessions were scheduled for a single day. All students in attendance electing to participate had the opportunity to complete questionnaires; those students whose parents had denied consent were excused from the sessions before the questionnaires were distributed. Questionnaires with preassigned numbers were distributed to each student listed on the class rosters; names were never entered on the instruments. Upon completion, questionnaires were placed in an envelope. Neither survey administrators nor school personnel saw the students' responses to any question. Class rosters were retained by the field supervisor to identify students absent at their scheduled session. One return visit was made to each school to conduct sessions in libraries or study halls for students absent from earlier sessions.

A total of 7,562 youth in grades 6, 7, and 8 completed the baseline questionnaire. The initial session resulted in a 90.3% rate of completion. A makeup session yielded another 5%, for a final completion rate of 95.3%. Parents of approximately 1.5% of the youth did not wish to have their children participate in the study and another 1% of the students chose not to participate. The remaining 2.2% of students were not present for both administrations. Participation rates were similar for all the schools in the study.

The questionnaire used in the prevention research was based on the instruments used in the 1974 and 1978 National Surveys of Adolescent Drinking (Rachal et al., 1980). The questionnaire focused on major prevention concepts: a) the invitation of experimentation, b) the transition to patterns of abuse, c) the exposure to school and community prevention efforts, and d) the effects of these efforts on invitation and transition. The key questions on usage were the following: "About how old were you when you first tried (type of drug)" and a follow up, "How many times have you *ever* used (type of drug)?" A question on maximum amount of alcohol ever consumed was also included. Data on basic sociodemographic characteristics and risk factors for drug abuse were also collected.

Results

The reports by youth attending 6th, 7th, and 8th grade showed dramatic increases in the level of initiation of abuse and negative consequences through the years of early adolescence. Few youths attending 6th grade reported alcohol or marijuana use; 13% said they had never had more than two drinks at a time, 4% reported having been drunk, and 7% had tried marijuana. Neither current nor frequent use of alcohol or marijuana was common. In 7th grade these rates were double and in 8th grade they doubled again. Among youth in 8th grade, experience with alcohol and marijuana use was much greater: 38% reported at least one episode of drinking two or more drinks, 29% reported being drunk at least once, and 27% had tried marijuana. For 8th graders, some behavior indicating risks of abuse is reported: 7% were having problems with their families because of their alcohol use in the past year, 12% had been drinking until they were drunk in the past month, 8% had used marijuana ten or more times, and 9% had gone to school while drunk or high in the past year.

It is also important to note the nature of initiation of alcohol and drug abuse for different types of youths. To describe the nature of initiation in middle school, three levels of abuse were defined. The first level was *drinking 2 or more full drinks (at least 2 ounces of pure alcohol) at one time*. A second level was *progression to trying marijuana*. The third level was *trying drugs in addition to alcohol and marijuana* (such as cocaine, uppers, downers, or psychedelics). The levels form a hierarchy of initiation of increasingly more serious levels of abuse. This description also provides a way to compare the nature and extent of abuse among different types of youths. For example, girls are often assumed to be at a lower risk of involvement in alcohol and drug abuse. The data in Table 1 support this assumption for youths in 6th grade. By 8th grade, however, the level of initiation is similar for boys and girls.

To further test some of the assumptions about the types of youths at the greatest risk for initiation of abuse in middle schools, multivariate analyses were conducted. A logistic-regression model was used to predict whether youths had initiated abuse of any type: alcohol, marijuana, or other drugs. The regression equation included variables controlling for sex, grade level, race, school location (urban/suburban or rural/suburban), family structure (single parent or two-parent family), and other risk factors.

After these other factors are statistically identified in a multivariate analysis, rates of initiation of abuse often do not differ significantly across sex, race, and urban/rural groups. Although demographic differences do not seem to be important correlates of abuse, some types of behavior seem to indicate major risks of abuse. The major risk factors are (a) poor school performance, (b) early initiation (before the 11th birthday) of regular smoking, (c) having friends who do not disapprove of alcohol or marijuana use, and (d) involvement with older teenagers or adults. The comparative odds ratios are 6.13 ($x^2 = 18.42$ $df = 1$ $p < .0001$) for regular smoking before 11 years of age, 3.71 ($x^2 = 47.32$ $df = 1$ $p < .001$) for friends who don't disapprove of alcohol use, 3.11 ($x^2 = 118.62$ $df = 2$ $p < .001$) for grades below a C average, and 2.38 ($x^2 = 59.66$ $df = 1$ $p < .001$) for hanging around with older teenagers or adults. These results indicate that youths who start smoking regularly before the age of 11 are 6 times more likely to initiate alcohol and drug abuse in middle school than similar students who do not start smoking. Compared to students of the same age, race, sex, and other characteristics who have grade averages of As and Bs, students with grades

Table 1
Level of Initiation of Alcohol and Drug Abuse by Youth in Different Years of Middle School

	Males			Females		
Level of Abuse	6th n =	7th n =	8th n =	6th n =	7th n =	8th n =
	%	%	%	%	%	%
Drank 2 or more drinks (1 oz of AA) at one time	11.6	16.5	18.3	6.4	11.7	14.5
Tried marijuana in addition to 2 or more drinks	5.2	10.8	17.9	3.8	7.0	14.7
Tried other drugs (uppers, downers, cocaine, psychedelics) in addition to marijuana and/or alcohol	3.9	7.0	11.5	1.9	6.5	11.9
TOTAL INITIATING ABUSE	20.7	35.0	47.7	12.1	25.2	41.1

averaging below C are three times more likely to initiate abuse in early adolescence.

Discussion

The results of this study demonstrate the rapid escalation in the initiation of alcohol and drug abuse among youths through the middle school years. To reduce this escalation, prevention programs are needed both before and during middle school. Programs in the elementary schools can help provide the foundation for knowledge, skills, and attitudes and can help young adolescents make healthy decisions about alcohol and drugs. This foundation, however, may not be sufficient. The programs in the elementary schools may be too abstract for preadolescent youth, most of whom have not been exposed to drugs. Thus, prevention messages may need to be reinforced by programs in the middle school years focusing on situations in which most adolescents face the concrete decision on whether to use or not use. Prevention programs during the middle school are needed to help youths reject any initial use and to help support their decision not to use.

The findings in the current study also suggest that additional prevention programs need to be provided to those youths with a high risk of abuse; those whose school performance is low and those who have begun to smoke regularly. Because many youths will make the initial decision to abuse, prevention programs must also discourage further abuse without excessive stigmatization or alienation. Intervention to identify students with alcohol and drug abuse during the middle school years may be of limited use. Given this limited extent of use and the lack of immediate detectable negative consequences, it would be extremely difficult to identify youths who have initiated some type of alcohol or drug abuse. More general interventions for high risk youth, which include alcohol and drug abuse prevention components, have the potential to become effective. Including effective alcohol and drug prevention components in programs targeted for these high risk youths may help prevent or delay initiation and reduce the long-term consequences associated with early initiation.

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A Counseling Approach to Alcohol Education in Middle Schools

Emily Garfield Ostrower

Alcohol abuse in the United States is a pervasive problem affecting many children and their families. There are 100 million drinkers in the United States, and 10 million are chronic abusers; drunk drivers kill 28,000 people each year on the nation's highways; alcohol is associated with about 69% of all drownings; it is a factor in approximately 70% of all deaths and 63% of all injuries from falls; and $19 billion a year is lost to business, government, and industry because of decreased work productivity caused by alcohol abuse (Channing L. Bete Co., 1984). Of course, behind these numbers are the despair and anguish suffered by millions of individuals and families because they or others in their lives are alcoholics. A counselor who works with youngsters in a public school often sees the reality of alcohol abuse translated into school problems for children, such as poor academic performance, low self-esteem, truancy, school phobia, aggressive or disruptive classroom behavior, withdrawal, depression, or difficulty relating to peers.

Because of concern for the pervasiveness with which I was seeing problems caused by alcoholism, I developed a curriculum and program, specifically for middle school youngsters (Grades 6–8), to focus on alcohol and the personal problems associated with alcoholism. The program, titled "What We Need To Know About Alcohol," had three objectives:

1. To provide correct information on the subject, so that students can begin to make informed and reasoned decisions about their own drinking.
2. To offer an educational process that fosters the development of decision-making skills, so that students will be able to make responsible choices when confronted with situations involving alcohol.
3. To develop a counseling and referral system to help specific youngsters cope with personal and family difficulties that occur

and to enable them to admit that they or someone in their family is abusing alcohol.

Throughout the program these three objectives were carefully integrated so each contributed to the importance of the other. Presentation of a program that imparts only the facts about alcohol abuse is like teaching youngsters to swim without providing practice time in the water. Similarly, students who study alcohol need exercises in which they can apply their knowledge to potential situations in real life. In fact, offering information alone has the effect of reducing youngsters' concerns about alcohol use. Moreover, I believe that simple alcohol awareness programs, in their effort to impart the basic facts, can be quite dangerous.

Students also need help to understand the great dangers of alcohol abuse and require a controlled environment in which to act out ways of preventing those dangers. Consequently, the decision-making component is crucial if students are to learn responsible drinking behavior. Finally, those who run the program must interface it with a readily available counseling and referral system for those students who have personal issues related to alcohol abuse.

The Program

An Overview

The program consisted of eight 50-minute sessions structured sequentially to meet each course objective. Given its strong emphasis on the physiological aspects of alcohol and alcohol abuse, the program usually was offered as part of the middle school science curriculum, but it also was integrated into social studies classes. Involvement in the program was voluntary and was determined by teachers' willingness to include it as part of their instruction. Participants consisted of heterogeneous groupings of students enrolled in preexisting science or social studies classes. The average class size was 22 students. In the two years the program was offered (1982–84) approximately 160 students from Grades 6, 7, and 8 participated.

In general, the educational objectives were achieved in the first three sessions, when students were provided with facts about the effects of alcohol use and abuse. This discussion extended to an exploration of the disease of alcoholism. In sessions 4 and 5 the program changed from an

objective, factual presentation into a more personal and affective one with speakers from Alcoholics Anonymous and Alateen. In this way, these sessions not only provided further information as part of the educational objective, but began to focus on rehabilitation and sources of help as part of the counseling objective. Once the educational stage had been set, Sessions 6 and 7 focused on developing decision-making skills by using specially designed activities. The last session emphasized the counseling objective of the program with a detailed discussion of sources of help. The counselor skillfully introduced channels through which students could reach out for help at any time.

Session 1

The first meeting was crucial in establishing the purpose and the tenor of the program. Special care was taken to avoid appearing either moralistic or judgmental. A candid and straightforward presentation of the facts and the attendant dangers of alcohol abuse were underscored. Statistics were shared to illustrate the magnitude of alcoholism in the United States today and to emphasize the prevalence of drinking and drunk driving accidents among the nation's teenagers. To put these numbers into clearer focus, the counselor pointed out that several youngsters in every classroom suffer from the emotional stress of living with an alcoholic.

The three course objectives were then listed and specifically discussed. The need to develop decision-making skills that are based on facts was stressed, as was the availability of help for those who wish it. At this juncture the issue of confidentiality was raised, so that ground rules could be established about sharing personal information. A bibliography for further reference, including resources such as Alcoholics Anonymous, Alanon, and Alateen, and a glossary of words they would be hearing in the coming meetings, was shared. The students kept a folder in which they placed these and other handouts. In addition, they were asked to collect magazine and newspaper clippings related to alcohol to help them become more cognizant of the ways alcohol affects their daily lives. Finally, the class took a true or false quiz that covered information that would be taught in the coming weeks.

Session 2

The second meeting was essentially factual and was the basis of the course's educational component. The students were shown a film, *Route*

One (General Services Administration, National Audiovisual Center, 1976), which deals with the science of alcohol and the effects of beverage alcohol on the human body. Particular emphasis is placed on the effect alcohol has on the brain. This general introduction was developed in greater depth through the use of several handouts I prepared for the program on the following topics: *How Alcohol Is Made, How Alcohol Is Metabolized in the Body, Alcohol's Effect on the Brain,* and *The Stages of Intoxication.* Three key points were made through the use of these handouts.

1. Alcohol is not digested the way food is, and, therefore, it enters the bloodstream much more rapidly, causing an immediate "high."
2. In an average 150 lb person, the liver can only break down 1 oz of alcohol in 1-1/2 hours, returning the unoxidized alcohol to the bloodstream to again wash over the brain.
3. The correlation between the amount of alcohol and its effect on certain brain functions explains the reasons for both the physiological and psychological changes related to alcohol use.

Once students understood these three points, several basic facts were presented:

- The faster one drinks, the faster one gets drunk.
- The bigger one is, the slower one gets drunk.
- Eating 15 minutes before drinking slows down the intoxication process.
- The alcoholic content of 12 oz of beer equals 1/2 oz of whiskey or 6 oz of wine.
- Carbonated mixers accelerate intoxication whereas water dilutes the alcohol.
- Black coffee, cold showers, and exercise do not sober a person up; only time does that.
- Alcohol mixed with other drugs can add up to more than the sum of the two and can lead to death.
- 50% of all children of alcoholic parents become alcoholics themselves.

Armed with these basic facts, students are equipped to begin to make decisions about alcohol use.

Session 3

In the third meeting the effects of long-term drinking were discussed. Alcoholism was introduced as a blameless disease that has medical, emotional, and spiritual consequences for its victims. Students were given a handout I prepared that includes candid information about the medical consequences for the alcoholic, attendant personality changes, and the effects of an alcoholic's drinking on family and friends. Theories of alcoholism were explored. This session was important, for it began to address, in personal terms, the realities of alcoholism for the abuser and for the abuser's family. Clearly, some youngsters will identify with such realities. The counselor must handle this type of information with sensitivity and be alert to youngsters for whom the discussion is particularly provocative.

A 10-question handout (Al-Anon Family Group, 1980), which indicates typical behavior of the alcoholic, was discussed in this session. Many experts believe that if a person can answer "yes" to three or more of the following questions (adapted from the handout), he or she may be an alcoholic.

1. Does the person talk about drinking? Often?
2. Is the amount of drinking increasing?
3. Does the person sometimes gulp drinks?
4. Is the drink used as a way to relax?
5. Does the person drink when alone?
6. Are there memory blanks after drinking?
7. Does the person need to drink to have fun?
8. Have hidden bottles been found?
9. Does the person drink in the morning to relieve a hangover?
10. Does the person miss school or work because of drinking?

This questionnaire often helps to clarify, for some youngsters, whether they are living with an alcoholic. Students in this program were given a homework assignment in which they were to write a description of an alcoholic personality after discussing certain typical traits including denial, obsessive interest in drinking, and an inability to keep promises. At the end of the session, each youngster was invited to write down questions he or she might wish to ask the guest speaker from Alcoholics Anonymous who was scheduled for the next meeting.

Session 4

In the fourth session a speaker presented information about Alcoholics Anonymous, its history, and its purpose as a fellowship for recovering alcoholics. Often the speakers related some aspects of their own experiences with alcoholism. Interaction between the speaker and the class was encouraged through a question and answer period. The questions the students had written in the previous meeting were presented to the speaker. These questions tended to reveal many of the students' own concerns and worries and typically were direct and to the point. For example, students repeatedly wondered how a person becomes an alcoholic and were interested to learn the details of the speaker's personal struggles with alcoholism. Some typical questions included the following:

- What was your behavior like when you were drunk?
- How did you get started drinking? How old were you?
- When did you realize that you were an alcoholic?
- Do you have children of your own? What did they say about your drinking?
- Did you ever beat them when you were drunk?
- What made you stop drinking?

This question and answer period helped students overcome their initial apprehension and freely engage with the speaker. Students were repeatedly surprised to see attractive, well-spoken people in this role, people who could be their mothers, fathers, teachers, or friends.

Session 5

During this meeting the focus shifted from the alcoholic to the child of an alcoholic parent. The session began with a particularly moving and sensitive film, *Lots of Kids Like Us* (Gerald T. Rogers Productions, 1983), which portrays a young boy's personal struggle to deal constructively with his father's alcoholism.

During the rest of the class time, students from Alateen, who also viewed the movie, answered class questions relating to their own experiences with a parent's alcoholism and the impact of Alateen on their lives. Often these youths were quite open in sharing their personal experiences and were articulate in describing the ways in which Alateen

had helped them. They served as positive role models for students, especially when they spoke about Alateen gatherings as a place where meaningful friendships develop and grow. For many youngsters, Alateen has taken the place of a gang or youth group. Consequently, it was offered to the class as an example of a viable social alternative. One 13-year-old spoke of the relief he felt to be able to hang around with friends without the pressure of having to drink.

As part of this presentation, a handout printed by Al-Anon Family Group (1980) and titled *Do You Need Alateen?* was shared with the students. Affirmative answers to many of the questions were interpreted as an indication that the student could benefit from Alateen. At the end of the session students talked informally and individually with the Alateen youngsters.

Finally, students were given a homework assignment to write a "Dear Abby" letter. Each youngster was instructed to write a letter to Abby as if they or someone they cared about were alcoholic. They were asked to embellish the letter with details about the drinking from the standpoint of its physical, mental, and spiritual effects. The letter could be fictional or true, and students could indicate truth or fiction at their own discretion. All letters were signed, and the promise of confidentiality was stressed.

This particular assignment was the most significant activity the students were asked to do during the course; many students used this opportunity to reveal how alcoholism was affecting their lives and in so doing took the first step in reaching out for help. The timing of this exercise is crucial for it to be effective. After five sessions of discussion about alcohol and alcoholism, including presentations by people who suffer it and cope with it daily, invariably someone stepped forward through the private, protective cover of the letter to share his or her personal story. At a later session several letters were selected and anonymously read to the students, who were asked to take the role of Abby in answering them.

This activity contributed to achievement of the three course objectives. First, having students describe alcoholism encouraged them to review the basic facts about alcohol use, the core of the educational component of the course. Second, this activity was a decision-making exercise that provided the class with ready-made situations to solve. Third, the activity could be used as a catharsis; that is, a youngster could fantasize a painful situation, real or imagined, and write a letter seeking help. Finally, the letter served as an assessment tool: The counselor

could identify those youngsters who indicated through this means, either implicitly or explicitly, that their story was, in fact, true. When an open revelation to the class is emotionally dangerous, especially to students of this age group, a private writing through an assignment may be a much easier means of communicating very real, painful experiences.

As a result of this exercise I began working individually with several youngsters to address the issue of their parents' alcoholism. One sixth grader wrote:

> My mom is an alcoholic. She has been for a long time. She went to AA, but it didn't work. Today she had to go to school [to meet my teachers] but she [woke up] drunk so I told my teacher she was sick. They made another time for her to come. I hope she isn't drunk then.

He ended the letter with a plea: "Please don't tell anybody in my family [that I told you about this]. They would be mad at me. You are the first person I told this to. Please don't tell anyone. P.S. I trust you not to tell anyone."

During a series of six weekly sessions, this sensitive youngster began to unburden himself and found comfort in being able to share and recount the daily, painful experience of his mother's alcoholism. It was particularly significant, however, that he was eventually able to tell his non-alcoholic father, who provided the emotional strength of the family, about his meetings with me. Our sessions ended at the close of the school year with his resolution to begin to attend a local Alateen meeting. It was especially important for him that he had his father's permission to do so.

Another youngster, a sixth-grade girl, revealed that her father was an alcoholic. Writing in the present tense, she described aspects of his behavior and its effect on her mother and siblings. During her first counseling session, she indicated she had not seen her father for three years. Clearly, however, the distress she was experiencing was as severe as if he had never left.

The next several sessions were intense and emotional. During the seventh session, she shared a photograph of her father, handsome and smiling, holding a can of beer. I asked her what she felt when she looked at that picture. She answered that it made her feel angry because "that beer" was a reminder of his drinking and what it did to their family. She added that she hated him for it. I responded, "But you have saved the picture." Her eyes welled up and she looked at me and said, "But I guess

I still love him too." The greatest indication that the sessions were helpful to this shy, quiet young girl was manifested in her report card the next term. She made the honor roll for the first time since entering middle school.

In both cases the students were regarded by their teachers as quiet, well-mannered young people. They were "good kids" who stood out neither academically nor socially. In short, their teachers would never have suspected the level of torment in their daily lives. Thus, the program in general and the "Dear Abby" letter specifically served as significant means of identifying those students who otherwise would never have received the much needed help of a counselor.

In addition to cases such as these, the "Dear Abby" letters uncovered other youngsters who needed different kinds of services. For instance, referrals were made to outside agencies when one student revealed that she was drinking uncontrollably and when another revealed that her alcoholic father was physically abusing her mother and her siblings.

A seventh-grade girl referred herself through a "Dear Abby" letter. In her first session she described how her alcoholic father, when intoxicated, would physically abuse both her mother and her older sister. Although she usually was not the target of his worst beatings, she became terror-stricken when they occurred. Clearly a dangerous situation existed; the proper legal authorities were notified, and an investigation ensued.

An 11-year-old girl was referred to me by the school psychologist, who suspected that the youngster had an incipient problem with alcohol. In my first meeting with her, she proudly boasted that she drank beer with her friends on the weekends. Her attendance, behavior, and academic performance were closely monitored at school. After a New Year's Eve party, she revealed in counseling that she had gotten very drunk and that her friends had rescued her after she vomited and collapsed on a snowbank. At the counseling session it was agreed that this situation was serious, and, with a certain amount of relief, she acknowledged that her parents needed to be informed. With my help she was able to tell her parents, and with their help she was able to seek counseling at a social service agency for alcoholic youngsters.

There was enough information in several other letters, in which students stated that the content was fictional, to lead me to suspect that these youngsters had more than a passing knowledge about the problems of alcoholism. Their progress in school was monitored.

Sessions 6 and 7

In Sessions 6 and 7 the emphasis shifted to the development of decision-making skills. Exercises were designed to encourage students to solve possible real-life problems involving alcohol use. Activities included the Dear Abby Letter described above and trigger films, such as *Drinking Driver: What Could You Do?* (Centron Films, 1978), *Party's Over* (General Services Administration, National Audiovisual Center, 1976), and *Trying Times* (Northern Virginia Educational Telecommunications Association, 1975), which dramatically present situations in which the viewer is left to decide how the characters might solve a problem.

Another useful tool was role playing. Students volunteered to play various roles outlined in a given situation. The following is a sample role play:

> Mike and Al are invited home with Ted after school. Ted's dad is an alcoholic. Ted's mom had thrown his dad out of the house weeks ago. On this particular day, however, as the boys enter Ted's house, they walk in on Ted's intoxicated dad. Ted's mom is screaming at him to leave. Ted's sister is crying.

This activity served several functions; one was catharsis for both participants and observers. As participants, students who were usually victims could play the victimizers; those who often felt helpless to solve the large problems of their families could take the roles of problem solvers. As observers, students were able to maintain some emotional distance as they watched the situation unfold. Lively class discussion was consistently generated through this activity.

In the final session of the course, another film, *Like Father, Like Son* (General Services Administration, National Audiovisual Center, 1976), was shown. This film not only provides a summary of key educational points made in the previous sessions, but, most important, through the dramatization of an alcoholic family, it imparts a hopeful view of the ways in which youngsters can cope with a parent's drinking by offering suggestions for rehabilitation and sources of help.

Students were asked to express their opinions about the program and offer suggestions for improving it. The course ended with the counselor's offer to be available to youngsters at any time.

Role of the Counselor and the Classroom Environment

Throughout such a program, the counselor serves as a teacher and must come to these sessions well-prepared with backup materials in case class participation falters. Moreover, the counselor must be knowledgeable about the long- and short-term physiological effects of alcohol abuse, as well as its social significance as the substance of choice among the current generation of American teenagers. The counselor must understand the psychological and emotional impact alcoholism has on the alcoholic family and, in particular, the special kinds of problems children of alcoholics experience. With this background knowledge, the counselor is ready to use his or her skills to facilitate the realization of the course objectives.

Although this program was presented in course form, it is important in such programs, given their potential emotional and personal content, that sensitivity and care be imparted along with the factual information. The use of group work skills is essential while answering questions and encouraging class discussion. Youngsters need to feel safe to discuss the various aspects of alcohol and alcoholism, and the counselor at all times must be aware that there are a number of students in every class who, without knowledge of school personnel, live daily with the pain and shame of alcoholism. Giving them permission to seek help starts with the counselor's continual attempts to create a nonjudgmental, sensitive, and caring classroom environment.

Students are prone to pass judgments that drinking is evil or, at the other extreme, that if a person does not drink he or she is not one of the crowd. By encouraging students to respond through class discussion to these comments, in an effort to dispel the former notion or expose the elements of peer pressure in the latter, a classroom environment of openness and safety can be established. Therefore, the counselor's role is one in which information is imparted and discussion of ways to improve decision-making abilities is encouraged. The subject matter, although it is the core around which the class is built, must always be secondary to the group process. Ultimately, the goals for the course will be achieved through the group process. For those youngsters who have personal problems with alcoholism, it is often the counselor to whom they will eventually turn if the classroom experience leads them to believe that it is safe to do so.

One particularly important aspect of the group work approach is the way confidentiality is handled. Children of alcoholics simultaneously experience both denial of the problem and shame that it occurs. To protect them, the class must decide that any personal information shared is not to be discussed outside the class. The counselor must stress that sharing of personal information is an act of courage and faith and must be treated with care and compassion. The counselor, therefore, must handle personal information for the benefit of the entire group, improving the understanding of all students while simultaneously offering protection through confidentiality to those who reach out for help. This climate is essential in realizing the third objective of the course.

Conclusion

Alcohol and alcohol abuse is pervasive in American society today. Its impact on the lives of young people has been well documented in tragedies that have had a significant spillover effect on the academic and emotional functioning of children in school. Often poor academic performance, erratic attendance, or inappropriate behavior is, in fact, symptomatic of alcohol abuse either by the student or by a member of the student's family.

Thus, it is imperative that schools offer programs to improve students' understanding of alcohol and alcoholism. Not only must they learn the facts about alcohol and alcohol abuse, but they must be equipped with the skills to make responsible decisions when they confront alcohol in their daily lives. Teaching only the facts without also including a decision-making component has the effect of minimizing students' anxiety while potentially increasing their chances of experimentation. Finally, by their design and intent, effective alcohol education programs must encourage youngsters who have personal experiences with alcohol abuse to come forth, either directly or indirectly, for help. A referral system and sources of help must be readily available.

References

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Trying times [Film]. (1975). Annandale, VA: Northern Virginia Educational Telecommunications Association.

Additional Resources

Books for Middle School Children

Channing L. Bete Co. (1984). *Alcoholic in the family* (Scriptographic Booklets). South Deerfield, MA: Author.

Channing L. Bete Co. (1986). *About drinking and driving* (Scriptographic Booklets). South Deerfield, MA: Author.

Englebardt, S. L. (1975). *Kids and alcohol: The deadliest drug.* New York: Lothrop, Lee and Shepard.

Houser, N. W. (1969). *Drugs: Facts on their use and abuse.* New York: Lothrop, Lee and Shepard.

Hyde, M. O. (1978). *Addictions: Gambling, smoking, cocaine use and others.* New York: McGraw-Hill.

Lee, E., & Israel, E. (1975). *Alcohol and you.* New York: Julian Messner.

Marr, J. S. (1970). *The good drug and bad drug.* New York: Evans.

Seixas, J. S. (1979). *Living with a parent who drinks too much.* New York: Greenwillow Books.

Swertha, E., & Swertha, A. (1979). *Marijuana*. New York: Franklin Watts.

U.S. Department of Health and Human Services, National Institute of Alcohol Abuse and Alcoholism. (1977). *Thinking about driving* (pamphlet). Washington, DC: Author.

Resources for Curriculum Development

AA Publications/AA World Services, Box 459, Grand Central Station, New York, NY 10017.

Al-Anon Family Group Headquarters, P.O. Box 182, Madison Square Station, New York, NY 10010.

Alcohol Resource Center, 474 Center Street, Newton, MA 02158.

Mothers Against Drunk Driving, P.O. Box 18260, Fort Worth, TX 76118.

National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

Scriptographic Booklets, Channing L. Bete Co., South Deerfield, MA 01373.

U.S. Department of Health and Human Services, National Institute of Alcohol Abuse and Alcoholism, Washington, DC 20402.

Preventing Adolescent Drug Abuse

Lindy L. LeCoq
Dave Capuzzi

As long as drugs exist, adolescent drug experimentation and social recreational use of these substances are likely to occur. Efforts aimed at eliminating all chemical substance use seem futile. A more realistic program of intervention may be drug abuse prevention. Because drug education programs that primarily dispense information about drugs and their psychological and physiological effects seem to be of questionable value (Horan, 1974; Stuart, 1974; Vogt, 1977), drug use/abuse prevention efforts have shifted toward more indirect methods (Horan, 1974). For example, Kandel (1980) proposed a model of progressive stages of drug involvement with behavior-specific antecedents. By using antecedents as signals, intervention may be aimed at specific use-level groups.

Attempts to intervene antecedently, focusing on fostering attitude and belief structures for responsible drug use and against drug abuse, may achieve better results when aimed at adolescents prior to age 12 or 13 (Jones, 1968, 1971). Developing coping skills, decision-making skills, and positive self-image also seems to be facilitative at this age, as well as with older age groups.

Attitudes toward drug use, however, may prove highly resistant or reactive to change. Those adolescents who endorse nonconventional values and behavior can be expected to resist traditional, values-oriented treatment (Wingard, Huba, & Bentler, 1979). Certain belief structures surrounding drug use seem more reactive than others. Schlegel and Norris (1980) found that beliefs associating drug use with pleasure are especially reactive. Thus, while attempting to dispose adolescents to hold less favorable attitudes toward drug use, persuasion that portrays the activity as unpleasant may increase positive beliefs and strengthen behavioral intention. Appealing to other components in the belief structure, especially perceptions of personal control of actions while intoxicated, may reduce intentions and behavior regarding marijuana smoking (Schlegel & Norris, 1980).

Carney's (1972) longitudinal examination of values clarification programs in public schools indicated that students who participated in

these classes had less initial use of alcohol and marijuana than those who did not. As Aubrey (1973) stated:

> The decision-making process....to abuse or not abuse drugs, is inexorably interwoven with the entire fabric of the individual's value system. As a consequence all drug programs must begin and end with recognition of this reality. (p. 5)

Initiation into use of illicit drugs other than marijuana seems to be predicted by poor parent-child relationships, parent and peer licit and illicit drug-using models, and feelings of depression (Kandel, 1980). At this stage of drug involvement, referral for family counseling and individual therapy may be the required intervention. Because drug dependence by any member of a family will create stress and compensatory shifts of behavior within the family unit, developing a treatment plan for every member of the chemically dependent family seems preferable (Wegscheider, 1979). When entire family participation is not achievable, community resources, such as Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, and Al-Ateen, may provide needed support services to family members.

In addition to establishing an attitude of acceptance and caring about all adolescents, the school and guidance department can best serve students by fostering a climate of trust and acceptance toward drug-experimenting youth, without condoning the behavior (Aubrey, 1973). The school guidance department can make a commitment to assist adolescents who are engaging in (or contemplating) licit or illicit drug experimentation by establishing a group counseling program. This article describes an eight-session model for a group counseling program within the school setting for preventing drug abuse.

A Group Counseling Model

This proposed program will help counselors facilitate building those skills that have been identified as being helpful to adolescents who are at the point of making choices regarding initiation of chemical substance use and abuse (Aubrey, 1973; Jessor, Jessor, & Finney, 1973; Jones, 1968, 1971; Kandel, 1980). The program is designed to help adolescents identify and modify personal coping behaviors, learn new communication and interpersonal relationships skills, recognize and build on personal strengths, take responsibility for personal decisions, choices,

and behavior, and integrate values, life-styles, and life goals with behavior choice and decision making.

Session I: Developing Awareness of Group Functions and Defining Responsible Chemical Substance Use

The purposes of Session I are to express structure, rules, and processes of the group, to become acquainted with group members, and to define responsible chemical substance use. The materials needed are paper, pens or pencils, chalkboard and chalk, and the handouts "Feedback," "Definition of Self-Disclosure," and "Identifying Environmental Pressures." The "Feedback" handout states:

> Feedback is a way of helping another person to consider changing behavior. It is communication to a person (or group) that gives that person information about how he or she affects others. As in a guided missile system, feedback helps an individual keep behavior on target and thus better achieve goals.

Some criteria for useful feedback are:

1. *It is descriptive rather than evaluative.* By describing one's own reaction, it leaves the individual free to use it or not use it as he or she sees fit. Avoiding evaluative language reduces the need for the individual to react defensively.
2. *It is specific rather than general.* To be told that one is "dominating" will probably not be as useful as to be told that "just now when we were deciding the issue, you did not listen to what others said and I felt forced to accept your arguments or be attacked by you."
3. *It takes into account the needs of both the receiver and giver of feedback.* Feedback can be destructive when it serves only one's own needs and fails to consider the needs of the person on the receiving end.
4. *It is directed toward behavior that the receiver can do something about.* Frustration is only increased when a person is reminded of some shortcoming that is resistant to change.
5. *It is solicited rather than imposed.* Feedback is most useful when the receiver has formulated the kind of question that those observing can help answer.

6. *It is well timed.* In general, feedback is most useful at the earliest opportunity after the given behavior.
7. *It is checked to ensure clear communication.* One way of doing this is to have the receiver try to rephrase the feedback received to see whether it corresponds to what the sender had in mind (paraphrase).
8. *When feedback is given in a training group, both giver and receiver have the opportunity to check with others in the group on the accuracy of the feedback.*

Feedback is a way of giving help. It is a corrective mechanism for individuals who want to learn how well their behavior matches their intentions; it is a means for establishing one's identity.

The "Definition of Self-Disclosure" handout (adapted from Johnson, 1971) states that:

> *Self-disclosure* means expressing your reaction to what is happening right now and bringing in any relevant information from your past experiences that helps someone else understand your reaction. Usually self-disclosure means you express your feelings about what is going on between you and your environment in the present. Self-disclosure can help other people understand your honest and sincere feelings and your reactions, which will help you build stronger, more trusting, and meaningful friendships. Self-disclosing carries with it the responsibility of listening to others and hearing their self-disclosure as well.

The "Identifying Environmental Pressures" handout is a chart that has the following column headings: Who, What Happens, When, Where, How, and Your Response.

There are five activities in Session I. The first is a large-group activity—*introduction of the group.* Instructions to facilitators are: (a) briefly introduce the co-facilitators and group members; (b) discuss the rules of the group (membership, confidentiality, attendance, promptness, participation); and (c) using the "Feedback" and "Definition of Self-Disclosure" handouts, discuss rules for constructive feedback, definition of self-disclosure, and the concept of consensus (time: 20–25 minutes).

The second is also a large-group activity—*getting acquainted.* Instructions to facilitators are: (a) have group members walk around and

non-verbally greet one another (handshake, smile, nod); (b) after a few minutes, have them pick a person they would like to know better; (c) instruct them to sit down together and interview each other for five minutes; (d) have pairs introduce each other by sharing information about the partner with the group, telling four or five important things about their partner; and (e) have the person who was introduced add one more important piece of information and describe his or her goals and expectations for the group experience (time: 35–40 minutes).

The third activity is a small-group discussion—*defining responsible substance use*. Instructions to facilitators are: (a) randomly divide the group in half with one facilitator per group; and (b) sit in two separate circles and give both groups the following assignment:

1. As a group, define (a) responsible chemical substance use and (b) chemical substance abuse. Concentrate on alcohol and marijuana use.
2. Choose a recorder and a spokesperson to report your group's definition to the large group.
3. You must reach consensus within your group.
4. Complete the assignment within 10 minutes (time: 15–20 minutes).

The fourth activity is a large-group discussion—*defining responsible chemical substance use*. Instructions to facilitators are: (a) have adolescents return to the large group and have spokespersons report their group definitions; (b) write each definition on the chalkboard; (c) negotiate with the full group and arrive at a consensus about their definitions; and (d) write the final definitions on the chalkboard and instruct group members to make a copy for themselves before leaving (time: 10 minutes). The fifth activity allows the group members to reflect and make comments about their observations, the definitions, and the experience (time: 5–10 minutes).

Other handouts include selected material from Do It Now Publications (Worden & Rosellini, 1981), from the National Institute of Alcohol Abuse and Alcoholism, and from the National Institute on Drug Abuse for group members to use for comparison with their group definitions. Homework involves having members keep a looseleaf journal in which homework assignments, handouts, and behavior change progress will be recorded. Experiences and insights gained during the group sessions also

may be included. Confidentiality concerns should be addressed by instructing the group members to use colors, letters, or numbers rather than names when identifying specific people.

The students are instructed to identify, during the next week, environmental sources exerting pressure on them to use or abuse chemical substances and to record how they respond to the pressure. Using the "Identifying Environmental Pressures" handout, they should determine who, what, where, when, and how the pressure occurs, along with their responses.

Session II: Identifying Coping Behaviors

The purposes of Session II are to develop awareness of feelings, thoughts, and how outward behavior flows from inner perceptions and to recognize some personal coping behaviors. Materials needed include pens or pencils, chalkboard and chalk, and the exercise sheets "Good Feelings," "Bad Feelings," and "Behavior Change Planning Guide." The "Good Feelings" worksheet is a chart for listing internal and external sources, good or positive feelings one has every day, and behavior—how one handles these feelings. The "Bad Feelings" worksheet asks for the same things about bad or negative feelings. The "Behavior Change Planning Guide" worksheet asks the following:

1. State your goal. What are you going to change in yourself, and in what situation will this change be occurring?
2. If your goal is complex, what are some smaller subgoals that are steps toward achieving the whole goal?
3. What specific behaviors will be involved in attaining each subgoal?
4. What barriers to achieving your goal(s) have you identified (thoughts, feelings, other people, situations, opportunities)?
5. What could you change antecedently to help yourself achieve your goal(s)?
6. Who could you observe or spend time with and learn from by "imitating"?
7. What specifically will you use to reward and reinforce yourself for achieving your goal(s) (self-praise, things or activities you like)?
8. How will you know you have accomplished your goal(s)?

There are four activities in Session II. The first is a large-group activity—*identifying feelings*. Instructions to facilitators are: (a) give each group member a "Good Feelings" worksheet, a "Bad Feelings" worksheet, and pens or pencils; (b) on the "Good Feelings" sheet, instruct students to list at least five different "good" or positive feelings they have almost every day; (c) on the other, have them list at least five "bad" or uncomfortable/negative feelings they have almost every day; and (d) when students are finished, instruct them to think about each feeling they listed and next to it, write a short, specific description of what they do when they have that feeling (time: 10–15 minutes).

The second is a small-group activity—*identifying sources of feelings*. Instructions to facilitators are: (a) have group members pair into dyads and share their lists with one another; and (b) using the left-hand column of the exercise sheets, instruct them to help each other identify whether each feeling is something that comes from within themselves or is being influenced by someone or something outside themselves (time: 10 minutes).

The third is a large-group activity—*sharing feelings*. Instructions to facilitators are: (a) have students return to the large group and instruct them to choose one positive and one negative feeling and share the feelings and their consequent behaviors with the group; (b) model by recording a feeling and behavior on the chalkboard; and (c) use the exercise to point out how thoughts and feelings lead to actions, how our actions show our ways of coping (including drug use and abuse), and what we tell ourselves are the reasons for our behaviors (time: 35–40 minutes).

The fourth activity is a large-group discussion—*homework assignment*. Instructions to facilitators are: (a) using the homework assignment from the previous session, ask each group member to identify one particular environmental pressure to use or abuse chemical substances from his or her own experience; (b) model by disclosing environmental pressures they experience and go around the circle until each member has shared an experience with the group; and (c) brainstorm alternative coping methods (time: 35–40 minutes).

The homework includes instructions to students to monitor their own and other people's coping methods during the week. Using the "Behavior Change Planning Guide," they should determine what they could do before, during, or after the pressure situation to help themselves. What rewards could they give themselves if they achieved their goals?

Session III: Using Relaxation and Guided Fantasy as Coping Methods

The purposes of Session III are to follow-up on observations about coping methods to provide relaxation training through guided fantasy and to establish a specific behavior change goal. The materials needed are comfortable chairs or pillows in a carpeted room.

There are two activities in Session III. The first is a small-group activity—*behavior change goals*. Instructions to facilitators are: (a) divide into two groups, one facilitator each; (b) model and then ask each group member to use his or her homework assignment to tell the group about one of their behavior change goals, what elements in their environment they will modify in the change process, and what rewards will be used to reinforce themselves (goals and rewards should be specific and attainable); and (c) urge group members to share their suggestions and encouragement, and from the observations group members have made about their own and other people's coping behaviors, help participants reemphasize when they are attributing blame for their own behavior to others and when they may be accepting someone else's responsibility (time: 30–35 minutes).

The second is a large-group activity—*guided fantasy*. Instructions to facilitators are: (a) return to full group, have participants get comfortable, darken the room, and ask group members to close their eyes; (b) use a pretaped guided fantasy or present your own; (c) when everyone is back to the present, turn up the lights and form a circle; and (d) allow participants to share their reactions to the exercise, where they were, and how they felt (time: 45–50 minutes). The following elements should be included in the guided fantasy.

1. Allot five minutes of concentration on deep breathing and "letting go" of tensions with exhalation of breath.
2. Ask participants to think of a special place that is all their own, where they can be comfortable and relaxed.
3. Guide participants through each of the five senses, bringing detail and dimension to their mental picture.
4. Give participants permission to be, alone or with someone, as long as they can be themselves, free from constraint and worry.

5. Have the group slowly return to the present. Tell them that the place they created in their mind is one to which they can return any time they wish. Caution them that their special place is not meant to be used as an escape but rather as a means of getting in touch with their internal selves and relaxing.

The homework includes instructions to students to initiate their behavior change plans and be sure to reward themselves. They should write experiences in their journals and mention times when they did not follow through with their plans. They should also refer to the "Behavior Change Planning Guide" and write down the specifics involved.

Session IV: Accepting Responsibility for Personal Choices

The purposes of Session IV are to reinforce the concepts of personal responsibility as opposed to blaming others, to introduce the concept of controlling one's own behavior as opposed to giving power away, and to recognize self-talk as a behavior shaper. The materials needed are paper and pencils or pens.

There are four activities in Session IV. The first is a large-group discussion—*homework assignment*. The instruction to facilitators is to discuss the homework assignment (time: 15–20 minutes): "Is your behavior change plan working for you? Are you reinforcing yourself? What kinds of responses are you getting from others? How are you feeling about it?"

The second activity is a large-group discussion—*accepting responsibility*. Instructions to facilitators are: (a) using examples, explain the differences between accepting responsibility for our own decisions and attributing blame to others when we are unhappy with the consequences of our decisions; and (b) make sure all members demonstrate a clear understanding of being responsible for their own behavior, of making choices and decisions, of experiencing consequences (both positive and nonpositive), and of projecting or attributing blame to others (time: 10–15 minutes).

The third is a large-group activity—*identifying attributions of responsibility*. Instructions to facilitators are: (a) enact short, emotion-packed adversarial situations; (b) provide dialogue that has statements such as "if it weren't for you...," "if only you didn't...," "you make me feel...," "it's all your fault that I...," and "if they weren't all against me, I'd..."; (c) during role play, have group members identify and write

down as many attributions of responsibility as they can; (d) allow three to five minutes; (e) go around the group, asking "How did it feel? Who is responsible for your feelings? Who is in control of your thoughts, feelings, and behavior?"; and (f) explain how we give away power when we let someone else make us think, feel, or behave, and include how we may give our personal power to control our thoughts, feelings, and behavior over to drugs or alcohol and can attribute any problems that occur to them (time: 40–50 minutes).

The fourth is a large-group activity—*accepting responsibility.* Instructions to facilitators are: (a) have group members relax, close their eyes, and breathe deeply for one or two minutes; (b) ask them to be aware of their "here and now" feelings; (c) start by saying "Now I am feeling _____, and I am responsible for that," and each member of the group will then use the same phrase, supplying their own feelings to the sentence; (d) go around three to five times; and (e) end the sequence by saying "Now I am feeling it is time to end our session, and I am responsible for that!" (time: 10–15 minutes).

The homework has students practice being aware of feelings and decisions they make, mentally rehearsing "I am responsible for the way I feel and the choices I make." In their journals, they should outline at least two significant situations during the week—one in which they found that they were attributing blame to someone else and another one in which they felt that they were receiving attributions of blame from someone else. They should write down how they responded and what they were saying to themselves mentally at the time.

Session V: Life Positions and Personal Control

The purposes of Session V are to reinforce concepts of personal responsibility for controlling behavior and to explore ways of coping with receiving attributions of blame. The materials needed are a stopwatch, the handout "Life Positions," and two "OK Corral" squares. The "OK Corral" exercise is a Transactional Analysis technique. The "Life Positions" handout states as follows:

1. "I'm OK; you're OK"—When people look at the world from this point of view they feel good about themselves and about other people. They generally are able to cope with situations positively and accept responsibility for their own behavior.

2. "I'm OK; you're not OK"—People who operate from this point of view are fairly distrustful of other people. Usually they believe that others are to blame for what happens to them. One way they cope with adversity is to shift responsibility from themselves to others.
3. "I'm not OK; you're OK"—People who feel this way generally are depressed a lot of the time. Often they do not think they compare favorably with other people or to their own self-expectations. They see themselves as having little control over their situation and commonly cope with adversity by withdrawing.
4. "I'm not OK; you're not OK"—Life is a "no win" situation from this person's point of view. People who feel this way lose any interest in living because it does not seem worth the effort. In extreme cases, they may commit suicide or kill other people. They blame themselves and the world for the situation they are in and see no way of getting out of it. They feel helpless and hopeless most of the time (adapted from James & Jongeward, 1978).

For the "OK Corral" exercise, the materials needed are large plain paper, like butcherpaper, enough to make two 3-foot by 3-foot or 4-foot by 4-foot squares, and a wide-tip felt marking pen. On each square, make a cross, dividing it into four equal squares. In each corner, write in one of the four life positions, as shown in Figure 1.

There are four activities in Session V. First, briefly discuss progress on behavior change plans. Any participant experiencing difficulty may be referred for additional individual counseling (time: 5 minutes).

The second activity is a large-group discussion—*homework assignment*. Instructions to facilitators are: (a) ask students "How does it feel to take responsibility for your own thoughts, feelings, and behavior? When you notice other people attributing blame to you for their own situations, what did you do, say, think, and feel?; (b) ask group members to share what they wrote in their journals; and (c) ask "What do the group members' responses to the situation say about the way they are coping? How could they change their responses? Would a different response change the behavior of the other people involved? Can we make other people change?" (time: 20–25 minutes).

The third is a large-group activity—*life positions*. Instruction to facilitators is: using the "Life Positions" handout, explain that what other people say and do toward us influences how we feel and think about

1 "I'm OK; you're OK"	2 "I'm OK; you're not OK"
3 "I'm not OK; you're not OK"	4 "I'm not OK; you're OK"

Figure 1
"OK Corral"

ourselves and that although we cannot always change the circumstances around us, we can change how we feel about ourselves (time: 10 minutes).

The fourth is a small-group activity—*OK Corral.* Instructions to facilitators are: (a) divide into two groups, one facilitator each; (b) using the "OK Corral" square, demonstrate assuming the role written in each square with "Now I am feeling..." statements; (c) have each group member do the same exercise, allowing two to three minutes in each role square; (d) have those group members who are not in the "corral" act as observers and recorders of the speaker's facial and physical gestures, voice inflections, and the statements made; and (e) allow three to five minutes for

each speaker to express feelings about being in each "corral" and to receive feedback from group members immediately after his or her turn (time: 65–75 minutes).

The homework has students continue monitoring their thoughts, feelings, and behaviors in difficult situations. They should listen to their self-talk. How does it influence their thoughts, feelings, and behaviors? Who is responsible for that?

Session VI: Building Communication Skills

The purpose of Session VI is to introduce and practice the third type of coping skill—communications skills—for clear understanding and better interpersonal relationships. The material needed is a timing device.

There are seven activities in Session VI. These exercises were adapted from Johnson (1972). The first is the behavior change progress reports (time: 5 minutes). The second activity is a large-group discussion—*homework assignment*. Instruction to facilitators is: ask students "How does your self-talk influence your thoughts, feelings, and behavior? What life positions do you find you are assuming?" (time: 10–15 minutes).

The third is a large-group activity—*communication skills*. Instructions to facilitators are: (a) introduce communication skills as a way to deal with unfair attributions and to develop more productive, rewarding, and new relationships; (b) ask for two volunteers or select two people to role play a conversation; (c) instruct one of the participants to talk about a matter of personal concern or interest without pause, regardless of the partner's response; (d) separately instruct the other participant to respond with irrelevant (noncomprehending or uninterested) statements (the conversation will last two to three minutes); (e) have the group observe the role play; (f) ask the partners to tell their feelings while experiencing this; and (g) ask group members to express their observations and feelings (time: 10 minutes).

The fourth is a continuation of the large-group activity—*communication skills*. Instructions to facilitators are: (a) using two different group members, instruct one to talk about a subject of personal interest or concern and instruct the other to respond by changing the subject to a matter of his or her own concern, allowing two to three minutes for the conversation; and (b) ask participants to discuss what occurred and how they felt about it—"Did the conversation initiator feel listened to and cared about?" (time: 10 minutes).

The fifth is a small-group activity—*paraphrase*. Instructions to facilitators are: (a) demonstrate the skill of paraphrasing; (b) have the group form dyads to practice paraphrasing their partners' "feeling" statements with the facilitators; and (c) return to the full group and ask how that felt—"Did you feel you were being listened to and heard?" (time: 10–15 minutes).

The sixth is a small-group activity—*negotiating for meaning*. Instructions to facilitators are: (a) demonstrate the skill of negotiating for meaning; (b) have the group form dyads and practice negotiating for meaning, with one partner making a personal statement and the other person responding by saying what probably was meant; (c) have the two discuss and negotiate until the originator of the statement can say the respondent has expressed the original meaning, with each person doing this as initiator and respondent two to three times in sequence; and (d) observe and assist the dyads (time: 15–20 minutes).

The seventh activity is a large-group discussion. Instructions to facilitators are: (a) return to the full group and discuss reactions; and (b) ask students "Was it easy or hard to negotiate for meaning? Did you find you really felt 'heard'?" (time: 15 minutes).

The homework involves having the students observe others and monitor their own communication patterns during the week. They should practice communication with the paraphrase and negotiating for meaning methods with at least two different people and write about it in their journals.

Session VII: Enhancing Positive Self-Concept

The purposes of Session VII are to continue building coping and communication skills, to identify strengths, and to foster positive self-concept. The materials needed are prepared 3 x 5 index cards, paper, and pencils or pens. An example of an index card is displayed in Figure 2.

There are four activities in Session VII. The first is the behavior change progress report (time: 5 minutes). The second activity is to share homework assignment experiences (time: 5 minutes).

The third is a small-group activity—*personal strengths*. Instructions to facilitators are: (a) divide into two groups, one facilitator per group; (b) instruct group members to make two lists—one of their past accomplishments and one of their perceived personal strengths; (c) have each person share the list with the group, with a facilitator perhaps modeling by going first; (d) when each member has completed reading his or her

list, have the other group members each add one other observed strength to that person's list by writing on the 3 x 5 index cards provided; (e) instruct the person receiving the feedback to remain quiet until all group members have given their positive additional strength statements; (f) when all have completed giving their verbal feedback, have them pass their cards to that person; (g) immediately go to the next person who will read his or her own list of accomplishments and strengths, again with the group providing a round of verbal feedback, accompanied by the 3 x 5 index cards; and (h) after all group members have read their lists and received feedback, ask "Why is it hard to say and hear nice things about yourself? What happens when you like yourself?" (time: 60–70 minutes).

The fourth is a continuation of the small-group activity—*identifying barriers*. Instructions to facilitators are: (a) after discussion, model and have each group member ask the other group members to help them identify attitudes, behavior, or environmental forces keeping them from using their strengths; (b) honest, constructive feedback is essential at this point—wherever drugs infringe on the individual's strengths or his or her use of strengths, acknowledge it; and (c) encourage participants to paraphrase and negotiate for meaning so that the feedback is understood accurately (time: 25–30 minutes).

The homework has students bring to the next group meeting a list of one, two, or three strengths on which they would like to build. They should identify any barriers preventing their use of that strength. How might they overcome those barriers?

NAME

I see you as a person who:

And I believe that because:

YOUR NAME

Figure 2
Index Card Format

Session VIII: Terminating the Group

The purposes of Session VIII are to clear up unfinished business, to express appreciation, to give and receive positive feedback, and to give closure to the group.

There are five activities in Session VIII. The first activity is to discuss progress on strength-building goals. Emphasize that the process of increasing strengths is one that is ongoing and that the same skills can be applied to other behavior change goals (time: 10–15 minutes).

The second is a large-group activity—*life goals*. Instructions to facilitators are: (a) instruct each group member to rank order all the life goals they have listed; (b) then have them select the top one to reveal to the group; and (c) ask "What does the goal say about your values and lifestyle preferences? How will chemical substance use fit into your lifestyle? How could chemical substance use or abuse keep you from achieving your goals?" (time: 55–60 minutes).

The third is a large-group activity—*expression of appreciation*. Instructions to facilitators are: (a) have the group form a circle with one person in the middle; (b) instruct that person to verbally or non-verbally express their positive feelings and appreciation for each person in the circle, with facilitators modeling first; and (c) encourage each group member to take a turn in the center of the circle (time: 15–20 minutes).

The fourth activity is to announce the option of having a follow-up session and to determine a time and date if the option is elected. The fifth activity is to tell everyone to express their own goodbyes for now.

Conclusion

School systems have an important role to play by providing drug use/abuse prevention programs. Program training aimed at helping children and young adolescents develop belief and attitude structures and decision-making and coping skills and providing accurate, timely information about chemical substances may prove to be extremely beneficial. Where long-term chemical substance use/abuse programs are initiated, careful assessment procedures will help ensure that the program goals and subgoals are achieved.

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Drug Information: The Facts About Drugs and Where to Go for Help

Edwin R. Gerler, Jr.
Stephen Moorhead

Elementary and middle school counselors are concerned about how to prevent substance abuse among young people and about how to identify substance abuse when it occurs. These professionals need to be knowledgeable about various substances and to have quick access to relevant information about drugs and their effects. In many elementary and middle schools, counselors need to concern themselves primarily with students' abuse of cigarettes and alcohol. In other schools, particularly in large urban and inner city areas, counselors must have sophisticated knowledge about a wide range of abuse substances.

Facts About Drugs and Their Effects

Counselors must be aware that drug education should always include more than just facts about drugs. Simply providing students with information may encourage experimentation. Nevertheless, it is important that elementary and middle school counselors have the best possible information themselves about commonly abused drugs. The following is a discussion of facts about various drugs, their effects, and evidence of abuse:

Commonly Abused Drugs

Alcohol. The drug of choice in late childhood and early adolescence is alcohol. Students often have easy access to beer, wine, wine coolers, and liquor at home. The effects of alcohol include decreased heart rate, blood pressure, and respiration, as well as impaired coordination, slurred speech, and fatigue. Long-term health problems related to alcohol abuse are psychological and physical dependence, liver damage, stomach problems, and vitamin depletion. Other hazards related to alcohol use are

driving while intoxicated, incurring Fetal Alcohol Syndrome, and combining the use of alcohol with other drugs. Physical evidence of its use and abuse include hidden bottles and the odor of alcohol.

Cannabis. This category includes marijuana and hashish, those products of the plant Cannabis Sativa. Street names for marijuana include pot, grass, herb, weed, and reefer. The substance looks like a weed with stems of various colors, usually brown, green, yellow, or red. Physical evidence of its use include smoking pipes, cigarette papers, clips for holding the cigarette, and rubber tubing. Hashish is more potent than marijuana and is processed from the resin of the plant. Commonly referred to as hash, it comes in the form of small, dense blocks or chunks that are smoked in a pipe or water pipe. Marijuana and hashish can also be cooked with food. The use of cannabis brings about red or glassy eyes, increased appetite, impaired coordination, forgetfulness, reduced attention span, animated behavior, and fatigue. The health effects of long-term use include damage to the respiratory system and possible heart damage.

Stimulants. This category includes various drugs: amphetamines (speed, uppers, bennies, dexies), methamphetamines (crank, crystal, crystal meth), look-alike amphetamines (hearts, crossroads, white crosses), caffeine (coffee, colas, chocolate), and nicotine (cigarettes, snuff, dip, chewing tobacco). Among other things, these substances cause loss of appetite, hyperactivity, and paranoia. The amphetamines, methamphetamines, and look-alike amphetamines in small doses create agitation, anxiety, confusion, blurred vision, heart palpitations, and tremors. Higher doses of these drugs bring about delirium, panic, aggression, hallucinations, psychoses, weight loss, and heart abnormalities. Psychological and physiological dependence are other consequences of abuse. The person will experience severe withdrawal symptoms after curtailing long-term use. Many types of stimulations are readily available to children and young adolescents, and are thus commonly used and abused by this age group.

Inhalants. This category also includes various substances: butyl nitrite (rush, locker room), nitrous oxide (laughing gas, whippets), amyl nitrite (poppers, snappers), aerosol sprays (paint cans, cleaning fluids), correction fluid, and solvents (gasoline, glue, paint thinner). Inhalants usually provide an immediate high. Inhaling these substances causes slurred speech, impaired coordination, drowsiness, runny nose, confusion, numbness, tears, headaches, and appetite loss. With high doses, respiratory depression, unconsciousness, or even death may result. As a

result of chronic use, temporary abnormalities have been found in the liver, kidneys, bone marrow. Other problems include gastritis, hepatitis, jaundice, peptic ulcers, and blood abnormalities. Persons who abuse these substances typically put the chemicals on a rag or in an empty bag and then inhale. Physical signs of abuse include empty containers and bags or cloths with odor of the substance.

Cocaine. Also known as coke, snow, lady, blow, and Bernice, this drug creates an immediate high, bringing about feelings of exhilaration, euphoria, high energy, and self-confidence that last for 15 to 30 minutes. After this intense "rush," the user will experience a certain degree of psychological depression, irritability, and nervousness. The chronic user will create a vicious cycle by continuing to use the drug to avoid the consequences of abuse. Serious health problems include heart attack, brain hemorrhage, liver and lung damage, seizures, and respiratory arrest. The drug is ingested by snorting, smoking (freebasing), or injecting. A type of freebase known as "crack" is also used. Physical evidence of cocaine abuse includes bits of white crystalline powder, short straws, mirrors, scissors, glass pipes, and round small screens.

Psychedelics. This category of drugs includes LSD (acid, blotter acid), phencyclidine (PCP angel dust, THC), mescaline and peyote (mesc, buttons), psilocybin (magic mushrooms), and MDA (love drug). The drugs are ingested in various ways: PCP, LSD, and mescaline are taken as pills or in powder form while psilocybin is chewed and swallowed. These substances alter the senses and often cause panic, nausea, and elevated blood pressure. The possible health consequence of LSD, mescaline, peyote, and psilocybin is psychological dependence. The hazards of MDA are similar to those associated with amphetamine use, and large doses of PCP may cause death from brain hemorrhage, heart, and lung failure, or repeated convulsions.

Depressants. These drugs include barbiturates (downers, barbs, yellow jackets), methaqualone (quaaludes, ludes, sopors), and tranquilizers (valium, librium, xanax, serax). They are swallowed as pills or capsules and cause impaired coordination, slurred speech, fatigue, and decreased respiration, pulse, and blood pressure. Persons who use depressants often appear drunk but without the odor of alcohol. When used with other substances such as alcohol, depressants may cause death. Chronic use of depressants results in physical dependence.

Narcotics. These substances include heroin (smack, hose, junk, black tar), codeine (empirin with codeine, Tylenol with codeine, cough medicines with codeine), meperidine (demerol), opium (paregoric) morphine,

and various other narcotics. These drugs are typically injected but are also taken in tablet, capsule, or liquid form. Narcotics cause decreased respiration, blood pressure, and pulse rate as well as fatigue, constricted pupils, weary eyes, and itching. They may also result in nausea and vomiting. Coma, shock, respiratory arrest, and death may result from very high doses. When these drugs are injected, AIDS may be spread through the sharing of unsterile needles.

Designer drugs. These substances are analogs of various narcotics and hallucinogens. They are designed to imitate the effects of illegal drugs. Often the effects of designer drugs are greater than the imitated drug. Designer narcotics may result in drooling, paralysis, tremors, and brain damage. Other designer drugs may cause impaired vision, chills, sweating, and faintness.

Sources of Additional Drug Information

Elementary and middle school counselors may wish to have convenient access to drug information that can be shared with parents, teachers, and principals. Numerous drug information organizations throughout the country provide free or inexpensive pamphlets and brochures which contain concise facts about drugs and drug abuse. A few of these centers of information are listed below:

The Drug Education Center
East Morehead Street
Charlotte, North Carolina 28202
(704) 336-3211

Do It Now (DIN) Publications
2050 East University Drive
Phoenix, Arizona 85034
(602) 257-0797

National Institute on Drug Abuse
5600 Fishers Lane
Rockville, Maryland 20857
(800) 638-2045

The Wisconsin Clearinghouse
1954 East Washington Avenue
Madison, Wisconsin 53704-5291
(608) 263-2797

The following is a selected list of useful drug information pamphlets and brochures published and distributed by the previously mentioned organizations.

Anderson, B., & Nash, A. (1987). *Teens and drugs: Information for parents*. Charlotte, NC: The Drug Education Center.

Davis, L. (1981). *All about alcohol*. Phoenix, AZ: DIN Publications.

Dye, C. (1983). *Coke-alikes: A close-up look at lookalike cocaine*. Phoenix, AZ: DIN Publications.

Dye, C. (1985). *ACID: LSD today*. Phoenix, AZ: DIN Publications.

Dye, C. (1985). *Marijuana: Health effects*. Phoenix, AZ: DIN Publications.

Dye, C. (1985). *MDA/MDM: The chemical pursuit of ecstasy*. Phoenix, AZ: DIN Publications.

Dye, C. (1986). *All about smoking: A special report for young people*. Phoenix, AZ: DIN Publications.

Dye, C. (1986). *Psilocybin: Demystifying the "Magic Mushroom."* Phoenix, AZ: DIN Publications.

Dye, C. (1986). *Smoking & health: A special report on the health effects of cigarettes*. Phoenix, AZ: DIN Publications.

Dye, C. (1987). *Cocaine: Waking up to a nightmare*. Phoenix, AZ: DIN Publications.

Dye, C. (1987). *Crack: The new cocaine*. Phoenix, AZ: DIN Publications.

Dye, C. (1987). *Drugs & alcohol: Simple facts about drug & alcohol combinations*. Phoenix, AZ: DIN Publications.

James, J. (1986). *All about marijuana: A special report for young people*. Phoenix, AZ: DIN Publications.

National Institute on Drug Abuse. (1986). *Hallucinogens and PCP*. Washington, DC: U.S. Government Printing Office.

National Institute on Drug Abuse. (1986). *Marijuana*. Washington, DC: U.S. Government Printing Office.

National Institute on Drug Abuse. (1986). *Opiates: Just say no*. Washington, DC: U.S. Government Printing Office.

National Institute on Drug Abuse. (1986). *Sedative-Hypnotics*. Washington, DC: U.S. Government Printing Office.

National Institute on Drug Abuse. (1986). *Stimulants and cocaine*. Washington, DC: U.S. Government Printing Office.

Parker, J. (1983). *Darvon/Darvocet & other prescription narcotics*. Phoenix, AZ: DIN Publications.

Parker, J. (1984). *The second generation lookalikes*. Phoenix, AZ: DIN Publications.

Parker, J. (1985). *Booze: A guide for young people*. Phoenix, AZ: DIN Publications.

Parker, J. (1985). *Heroin: The junk equation*. Phoenix, AZ: DIN Publications.

Parker, J. (1985). *Valium, Librium, and the Enzodiazepine Blues*. Phoenix, AZ: DIN Publications.

Parker, J. (1986). *Downers: The distressing facts about depressant drugs*. Phoenix, AZ: DIN Publications.

Parker, J. (1986). *All about downers: A special report for young people*. Phoenix, AZ: DIN Publications.

Parker, J. (1986). *All about sniffing: A special report for young people*. Phoenix, AZ: DIN Publications.

Parker, J. (1986). *All about speed: A special report for young people*. Phoenix, AZ: DIN Publications.

Parker, J. (1987). *Crystal, crank & speedy stuff: A close-up look at stimulant drugs*. Phoenix, AZ: DIN Publications.

Wisconsin Clearinghouse. (1981). *Alcohol and marijuana: Info for teens*. Madison, WI: Wisconsin Clearinghouse.

Facts About Drug Abuse Prevention and Intervention

Elementary and middle school counselors often coordinate the drug abuse prevention programs for schools. These programs usually involve collaboration between teachers and counselors and are part of the school curriculum. Counselors, however, need to have information available about a wide range of prevention and intervention services to make sure that all segments of the school population are being adequately served. What follows are some information sources counselors may find helpful in the area of drug abuse prevention and intervention.

Selected Sources of Information about Prevention and Intervention

Organizations throughout the country provide free or inexpensive pamphlets and brochures that give helpful information about prevention and intervention. A few of these centers of information are listed below:

Al-Anon Family Group Headquarters, Inc.
P.O. Box 862
Midtown Station
New York, New York 10018-0862
(212) 302-7240

Alcoholics Anonymous General Service
P.O. Box 459
Grand Central Station
New York, New York 10163
(212) 935-7075

Do It Now (DIN) Publications
2050 East University Drive
Phoenix, Arizona 85034
(602) 257-0797

Krames Communications
312 90th Street
Daly City, California 94015-1898
(415) 994-8800

National Institute on Drug Abuse
5600 Fishers Lane
Rockville, Maryland 20857
(800) 638-2045

The Wisconsin Clearinghouse
1954 East Washington Avenue
Madison, Wisconsin 53704-5291
(608) 263-2797

The following is a selected list of brief publications about prevention and intervention distributed by the above organizations.

Al-Anon. (1984). *A guide for the family of the alcoholic*. New York: Al-Anon Family Group Headquarters.

Al-Anon. (1984). *To the mother and father of an alcoholic*. New York: Al-Anon Family Group Headquarters.

Al-Anon. (1986). *So you love an alcoholic*. New York: Al-Anon Family Group Headquarters.

Alcoholics Anonymous. (1979). *Young people and A.A.* New York: Alcoholics Anonymous World Services.

Burkett, M. (1982). *Junk: A look at heroin treatment and alternatives.* Phoenix, AZ: DIN Publications.

Dye, C. (1986). *All about saying "No."* Phoenix, AZ: DIN Publications.

Inskeep-Fox, S. (1986). *Let's make a deal: A recovering parent's guide to winning through family negotiation.* Phoenix: AZ: DIN Publications.

Inskeep-Fox, S. (1986). *Theme song for recovery: A communication guide for recovering alcoholics and families of alcoholics.* Phoenix, AZ: DIN Publications.

Krames Communications. (1986). *Alcoholism in the family: What you can do.* Daly City, CA: Krames Communications.

Krames Communications. (1987). *Marijuana: A second look at a drug of isolation.* Daly City, CA: Krames Communications.

National Institute on Drug Abuse. (1980). *Drug abuse prevention for your family.* Washington, DC: U.S. Government Printing Office.

Parker, C. (1986). *Children of alcoholics: Growing up unheard.* Phoenix: AZ: DIN Publications.

Parker, J. (1986). *Everyday detox: A guide to recovery from almost anything.* Phoenix, AZ: DIN Publications.

Wisconsin Clearinghouse. (1984). *Young children and drugs: What parents can do.* Madison, WI: Wisconsin Clearinghouse.

School counselors and others who want to have the quickest access to current information about prevention and intervention programs will find the following toll-free telephone numbers useful:

(800) COCAINE: This cocaine hotline provides round-the-clock information and referral services for cocaine abusers. Reformed cocaine addict counselors offer help and referrals to public and private treatment centers.

(800) 258-2766: The Just Say No to Drugs Foundation provides information on this line to help schools establish "Just Say No" clubs.

(800) 554-KIDS: The National Federation of Parents for Drug Free Youth provide this number to help with preventing drug addiction among children and adolescents. The number also gives access to information about help for young people who are already abusing drugs. The service is available between 9:00 a.m. and 5:00 p.m.

(800) 662-HELP: The National Institute on Drug Abuse provides this hotline giving interested persons information about

cocaine abuse treatment centers. This hotline also supplies requests for free drug abuse materials.

(800) 241-9746: The "Pride Drug Information Line" provides information on how parents can form groups called PRIDE (Parent's Resource Institute for Drug Education). Persons calling this number can also get consulting and referrals to emergency health centers as well as taped information about substance abuse.

(800) 541-8787: This "Slam the Door on Drugs" hotline offers parents information on drug abuse prevention.

(800) 424-1616: The U.S. Department of Education receives requests on this hotline for a free copy of "What Works—Schools without Drugs," a resource that contains much valuable information.

Conclusion

Drug abuse is a societal problem that will not be overcome easily or quickly. Elementary and middle school counselors, however, will not be effective educators and prevention specialists unless they are equipped with the best information possible. Counselors need to be informed in order to consult effectively with parents, school administrators, and professionals in community agencies about matters related to substance abuse. Most importantly, school counselors must be well informed to counsel young people in the area of drug use and abuse.